Self-Assessment

BEAUTY BY BUFORD

NAME: _____ DATE OF BIRTH: _____ DATE: _____

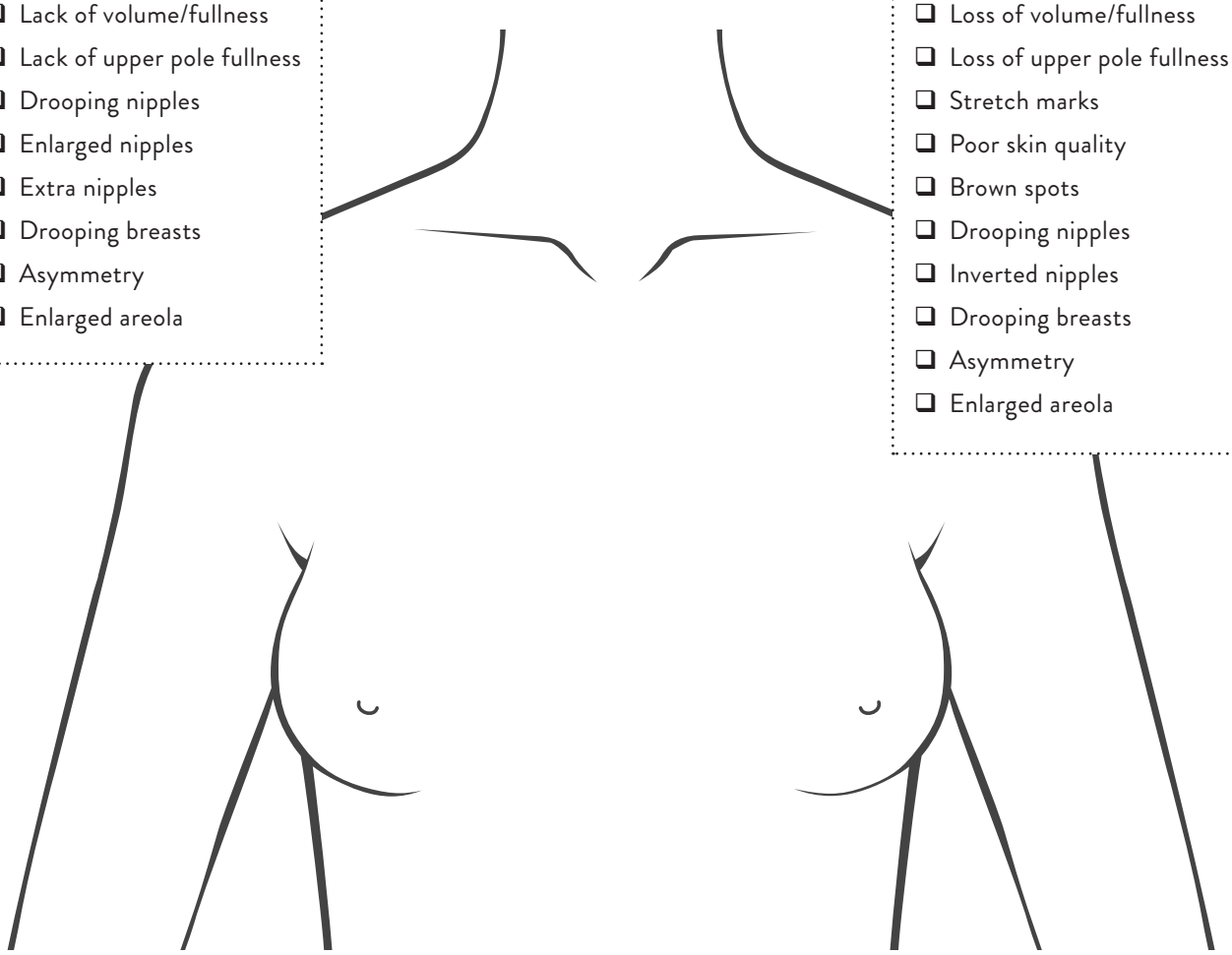
WHAT BRINGS YOU IN TODAY? _____

Select your breast concerns on the diagram below.

By sharing how you see yourself, we can best evaulate your aesthetic goals and select an appropriate treatment for you.

Pre-Existing Changes

- ❑ Lack of volume/fullness
- ❑ Lack of upper pole fullness
- ❑ Drooping nipples
- ❑ Enlarged nipples
- ❑ Extra nipples
- ❑ Drooping breasts
- ❑ Asymmetry
- ❑ Enlarged areola



Acquired Changes

- ❑ Loss of volume/fullness
- ❑ Loss of upper pole fullness
- ❑ Stretch marks
- ❑ Poor skin quality
- ❑ Brown spots
- ❑ Drooping nipples
- ❑ Inverted nipples
- ❑ Drooping breasts
- ❑ Asymmetry
- ❑ Enlarged areola

Please complete and return this form to the front desk before your consultation.